# STATE OF CONNECTICUT

*INSURANCE DEPARTMENT*

**Testimony of the Connecticut Insurance Department**

**before the**
**Insurance and Real Estate Committee**

**Tuesday, March 15, 2011**

**Raised Bill 1158 – An Act Concerning Utilization Review, Grievances and External Appeals Process of Health Carriers**

The Insurance Department submits this testimony relating to Raised Bill 1158 - An Act Concerning Utilization Review, Grievances and External Appeals Process of Health Carriers which has been raised at the request of the Insurance Department. The Department would like to thank the Committee for raising this bill on our behalf. My name is Beth Cook and I am Legal Counsel at the Connecticut Insurance Department.

The Insurance Department is proposing to amend current utilization review, grievance and external appeal statutes to adopt the National Association of Insurance Commissioners (NAIC) Models as a means of more fully complying with the requirements of the Patient Protection and Affordable Care Act of 2010 (P.L.111-148) (PPACA) as amended.

Sec. 2719 of the Public Health Service Act (PHSA) as amended by PPACA, requires that group health plans and health insurance issuers offering group or individual health insurance must implement an effective appeals process for appeals of coverage determinations and claims that complies with federal procedures set forth at section 2560.503-1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256).

Group health plans and health insurance issuers of group and individual health plans are also required to comply no later than July 1, 2011, with a state external review process that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act (EA Model) promulgated by the National Association of Insurance Commissioners (NAIC) model, or the plans and health insurance issuers will be subject to the federal programs established and administered by the US Department of Labor.

While the Department has amended the relevant statutes over the last few years to achieve more uniformity with the NAIC Models, in mid-January of this year, the US Health and Human Services Department (HHS) reviewed the existing State of Connecticut external appeal statutes and determined that the Connecticut statutes were not sufficiently compliant with all of the consumer protections in the most recent version of the NAIC EA Model and is requiring the Department to amend the Connecticut law to bring it into more substantial compliance in order to maintain state authority over external appeals. The consumer protections identified by HHS as needing revision would extend timeframes for consumers to file internal and external appeals and grievances, establish more liberal exhaustion procedures and expand the categories of adverse determination with a strict adherence to the NAIC Model for consumer protections in order to maintain state control of the process. Because of the dependency and inter-relationships of the external appeal process on the utilization and grievance processes,

we are also seeking to amend our utilization review statute and grievance statutes with those NAIC Models to ensure that these processes, which include new consumer protections for processes such as retrospective review and denials of other than medical necessity blend with the external appeal model. Attached to this testimony is a reference sheet that identifies the changes we are proposing to make to current statutes.

This has been an enormous drafting task and we want to thank the Committee's LCO attorney, Kumi Sato, for her work on this bill. The bill before you is still a work in progress. In fact, last Friday, March 11, HHS notified the Department that HHS is monitoring this legislative proposal and has identified changes we must make to satisfy federal requirements. HHS has made it very clear that they are watching this and our other PPACA proposals very closely for conformity to the federal law and if we do not enact proposals they believe meet the federal requirements, they will move to exempt state oversight where they have the right to do so. We look forward to working with you and all interested parties to put in place a final version that will fully satisfy the requirements of HHS and make certain that Connecticut maintains control of the external appeal processes for our consumers.

Thank you once again for raising this bill on our behalf and I would be happy to answer any questions you may have.

*An Act Concerning Utilization Review, Grievances and External Appeals Processes of Health Carriers*

## General Provisions

| Provision | Current Law | Proposed Bill *(new requirements in italics)* |
|---|---|---|
| Eligibility | Medical necessity denials for:<br>• Refusal to certify admission<br>• Denial of Service or Procedure<br>• Refusal to certify extension of stay<br>• Experimental & Investigational<br><br>Non-medical necessity denials (contractual denials)<br>• Internal Appeals Rights<br>• No eligibility for External Review | Medical necessity denials for:<br>• Refusal to certify admission<br>• Denial of Service or Procedure<br>• Refusal to certify extension of stay<br>• Experimental & Investigational<br>• *Eligibility to participate in health plan*<br><br>Non-medical necessity denials (contractual denials)<br>• Same<br>• Same<br>• *Rescissions* |
| Health Plan Eligibility for External Review | • Fully insured Connecticut situsedindividual and group health plans<br>→ Medical, dental, vision<br><br>• Self-funded Connecticut municipal/state plans<br><br>• DSS Programs (by MOU)<br>→ Charter Oak, Husky B, CT Pre-existing Conditions Plan | • Same<br><br>• *Must participate in Federal External Review Program; cannot use state programs*<br><br>• Same |
| Time Limit for Filing Internal Appeal | • Based on health plan guidelines | • *180 days* |
| Time Limit for Filing External Review | • 60 Days from Final Internal Appeal Denial | • *120 Days from Final Internal Appeal Denial* |
| Judicial Remedies Beyond External Review | • Binding on all parties | • *Notice of availability to File a Civil Suit in a Court of Competent Jurisdiction (Denials)*<br>• *Notice of Voluntary Alternative Dispute Resolution Options (Appeals)* |

## Expedited Reviews

| Provision | Current Law | Proposed Bill |
|---|---|---|
| Expedited Review | <u>Eligibility</u><br>• May cause or exacerbate an emergency or life threatening situation<br><br>• Eligible for External Review prior to exhausting Internal Appeals<br><br><u>Initial Health Plan Determinations</u><br>• Decision in (2) Business Days<br>• Continued stay in acute care hospital – (3) hours<br><br><u>Internal Appeal</u><br>• Decision in (2) Business Days<br><br><u>External Review</u><br>• Decision in (5) Business Days | <u>Eligibility</u><br>• Would seriously jeopardize the life or health of the covered person *or would jeopardize the covered person's ability to regain maximum function.*<br>• *<u>For Internal Appeals & External Reviews – Experimental/Investigational denials</u> entitled to expedited appeal if doctor certifies that "treatment would be significantly less effective if not promptly initiated".*<br>• Same<br><br><u>Initial Health Plan Determination</u><br>• *Decision in 24 hours*<br>• Same<br><br><u>Internal Appeal</u><br>• *Decision in 72 hours*<br><br><u>External Review</u><br>• Same<br>• |

## Standard Internal Appeals

| Provision | Current Law | Proposed Bill |
|---|---|---|
| Internal Appeal Levels | Group Health Plans<br>• Based on health plan guidelines. May include (1) or (2) levels of internal appeals<br><br>Individual Health Plans<br>• Based on health plan guidelines. May included (1) or (2) levels of internal appeals | Group Health Plans<br>• *Requirements established for (1) level Internal Appeals*<br><br>Individual Health Plans<br>• *Limited to (1) Level of Internal Appeal* |
| Timeframes | Prospective or Concurrent Services<br>*requiring pre-authorization*<br>• Decision – (2) Days<br>• Internal Appeal determinations – (30) Days<br><br>Services that do not require pre-authorization<br>• Claims paid in (45) Days<br>• Internal Appeal determination (60 Days) | *Prospective or Concurrent Services*<br>• *Decision – (15) Days*<br>• *Internal Appeal determination – (30) Days*<br><br>*Retrospective Services*<br>• *Decision – (30) Days*<br>• *Internal Appeal determination – (60) Days*<br><br>*Administrative Grievances*<br>• *Internal Appeal determination – (20) Days*<br><br>*Rescissions*<br>• *Internal Appeal determination – (15) Days* |
| Failure of Health Plan to Meet Timeframes | • Statutory interest payable for late claim payments. Potential fines for non-compliance during CID Market Conduct Reviews. | • Same<br><br>• *Internal Appeals deemed exhausted – immediately eligible for External Review* |

## Standard External Review

| Provision | Current Law | Proposed Bill |
|---|---|---|
| External Review - Standard Timeframes | Notification of External Review<br>• (5) Business Day<br><br>Preliminary Review & Determination of Eligibility<br>• (5) Business Days<br><br>Final Decision<br>• (30) Business Days | Notification of External Review<br>• *(1) Business Day*<br><br>Preliminary Review & Determination of Eligibility<br>• (5) Business Days<br><br>Final Decision<br>• *(45) Days* |
| Failure of Health Carrier to Meet Timeframes | • None | • *If health carrier fails to submit their medical appeals file to External Review entity within prescribed time frame, External Review entity may terminate the External Review and reverse the denial of benefits.* |